Behavior Health v Mental Health: More Than a Name Change

The issue of reassessing the perspective of viewing of mental health through the lens of behavioral health is gradually gaining momentum. The problem has been the issue address by Max Planck when he addressed why it requires so much time for science to advance. [1] Relative to behavioral health, US healthcare reimbursement has been focused on sick care as opposed to prevention and "managed care" that is becoming the focus or large corporation in order to reduce their self-funded insurance costs.

Today's reality is forcing research to meet the needs of providers by rethinking decades of fee-for-services as the means capturing revenue. In terms of why the focus is shifting, the following explains the scenario and consequences allowing research in mental/behavioral health to have become stagnant.
https://www.mcfip.net/upload/Medical%20Wisdom%20-%20Skewed%20by%20Science.pdf

https://neurosciencenews.com/mental-health-diagnosis-15051/

New research raises important questions on

[1] "A new scientific truth does not triumph by convincing its opponents and making them see the light, but rather because its opponents eventually die."
Max Planck

how mental illness is currently diagnosed

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Summary: *Researchers argue the existing categorical framework for mental illnesses needs to be revised, citing a substantial overlap between disorders, with most patients meeting the criteria for multiple disorders.*

Source: *TCD*

A study led by a psychologist from Trinity College Dublin raises important questions on how mental illness is currently diagnosed and whether these diagnoses accurately reflect the underlying neurobiology of mental illness.

The findings, just published in the leading peer-reviewed medical journal, *JAMA Psychiatry*, are significant in highlighting the need for more individualised approaches to defining mental illness.

In this study the researchers showed that a compulsive dimension of mental health maps onto various aspects of 'cognitive flexibility' better than an expert-assigned diagnosis. Cognitive flexibility reflects a set of brain processes that are thought to be essential for controlling our habits.

Prior research shows that habits play a role in a range of mental health conditions characterised by compulsive, repetitive behaviours. These include obsessive-compulsive disorder, the focus of the present study, but also binge-eating, excessive shopping and forms of addiction.

Mental disorders are currently defined in terms of diagnostic and statistical manual (DSM) diagnoses. They are labelled in categorical terms; patients either meet criteria or they don't. This is extremely important for making clinical decisions ? to treat, or not? but may not reflect the true nature of mental health and illness in the population.

There is now a substantial body of research suggesting that our existing categorical frameworks for mental illness need revision. This is in part because there is substantial overlap across disorders, with most patients meeting criteria for multiple disorders and the fact that many disorders share commonalities, such as compulsiveness.

In the current study, patients met an average of 3.7 concurrent diagnoses. Disorders are also highly heterogeneous – which means that two patients might have the same diagnosis, but have little to no overlapping symptoms and might respond in entirely different ways to the same treatment.

Focusing on obsessive-compulsive disorder (OCD), the findings of this study suggest that self-reported levels of compulsive behaviour are a better predictor of alterations in cognitive flexibility than whether someone has a diagnosis of OCD..

Commenting on the findings, lead author, Dr Claire Gillan said: “By defining mental health and illness in a way that is true to the biology of the brain and respects the reality that most mental illness varies in the population, it is hoped that we are charting a path towards a future where treatments can be prescribed on a more individualised basis, based on well-defined brain systems and circuits and crucially, with a higher rate of success.”

This study involved a collaboration between a team of researchers and clinicians at Trinity College Dublin, the Department of Psychology at New York University, New York State Psychiatric Institute, Harvard Medical School, the Warren Alpert Medical School of Brown University and the Hofstra Northwell School of Medicine.

ABOUT THIS NEUROSCIENCE RESEARCH ARTICLE

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Original Research: Closed access
“Comparison of the Association Between Goal-Directed Planning and Self-reported Compulsivity vs Obsessive-Compulsive Disorder Diagnosis”. Claire Gillan et al.
JAMA Psychiatry doi:10.1001/jamapsychiatry.2019.2998.

Abstract

Comparison of the Association Between Goal-Directed Planning and Self-reported Compulsivity vs Obsessive-Compulsive Disorder Diagnosis

Importance
Dimensional definitions of transdiagnostic mental health problems have been suggested as an alternative to categorical diagnoses, having the advantage of capturing heterogeneity within diagnostic categories and similarity across them and bridging more naturally psychological and neural substrates.

Objective
To examine whether a self-reported compulsivity dimension has a stronger association with goal-directed and related higher-order cognitive deficits compared with a diagnosis of obsessive-compulsive disorder (OCD).

Design, Setting, and Participants
In this cross-sectional study, patients with OCD and/or generalized anxiety disorder (GAD) from across the United States completed a telephone-based diagnostic interview by a trained rater, internet-based cognitive testing, and self-reported clinical assessments from October 8, 2015, to October 1, 2017. Follow-up data were collected to test for replicability.

Main Outcomes and Measures
Performance was measured on a test of goal-directed planning and cognitive flexibility (Wisconsin Card Sorting Test [WCST]) and a test of abstract reasoning. Clinical variables included DSM-5 diagnosis of OCD and GAD and 3 psychiatric symptom dimensions (general distress, compulsivity, and obsessionality) derived from a factor analysis.

Results
Of 285 individuals in the analysis (mean [SD] age, 32 [12] years; age range, 18-77 years; 219 [76.8%] female), 111 had OCD; 82, GAD; and 92, OCD and GAD. A diagnosis of OCD was not associated with goal-directed performance compared with GAD at baseline (β [SE], −0.02 [0.02]; P = .18). In contrast, a compulsivity dimension was negatively associated with goal-directed performance (β [SE], −0.05 [0.02]; P = .003). Results for abstract reasoning task and WCST mirrored this pattern; the compulsivity dimension was associated with abstract reasoning (β [SE], 2.99 [0.63]; P < .001) and several indicators of WCST performance (eg, categories completed: β [SE], −0.57 [0.09]; P < .001), whereas OCD diagnosis was not (abstract reasoning: β [SE], 0.39 [0.66]; P = .56; categories completed: β [SE], −0.09 [0.10]; P = .38). Other symptom dimensions relevant to OCD, obsessionality, and general distress had no reliable association with goal-directed performance, WCST, or abstract reasoning. Obsessionality had a positive association with requiring more trials to reach the first category on the WCST at baseline (β [SE], 2.92 [1.39]; P = .04), and general distress was associated with impaired goal-directed performance at baseline (β [SE],−0.04 [0.02]; P = .01). However, unlike the key results of this study, neither survived correction for multiple comparisons or was replicated at follow-up testing.

Conclusions and Relevance
Deficits in goal-directed planning in OCD may be more strongly associated with a compulsivity dimension than with OCD diagnosis. This result may have implications for research assessing the association between brain mechanisms and clinical manifestations and for understanding the structure of mental illness.